FEB 24 2003

No. 02-469

In the Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN, PETITIONER

v.

KENNETH L. NORD

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

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QUESTION PRESENTED

Whether the administrator of an ERISA-covered disability plan must follow a "treating physician rule" in determining a participant's disability, so that the administrator is required to accept a treating physician's opinion on disability unless the administrator rebuts that opinion in writing based upon substantial evidence in the record.

TABLE OF CONTENTS

	Page
Interest of the United States	1
Statement	1
Summary of argument	6
Argument:	
A "treating physician rule" should not be applied by courts in reviewing disability determinations under plans covered by ERISA	7
A. A treating physician rule is inappropriate and unnecessary under ERISA	8
B. Application of a treating physician rule under the Social Security Act does not justify judicial imposition of a rule under ERISA	19
C. The case should be remanded for further proceedings in which special weight need not be given to the opinions of respondent's treating physicians	27
Conclusion	29

TABLE OF AUTHORITIES

Cases:

Amos v. *Director, OWCP*, 153 F.2d 1051 (9th Cir. 1998), cert. denied, 528 U.S. 809 (1999)	24
Anderson v. *City of Bessemer*, 470 U.S. 564 (1985)	19
Anderson v. *Blue Cross/Blue Shield*, 907 F.2d 1072 (11th Cir. 1990)	14
Anderson v. *Liberty Lobby, Inc.*, 477 U.S. 342 (1986)	13
Ashe v. *Workmen's Comp. Appeal Bd.*, 648 A.2d 1305 (Pa. Commw. Ct. 1994)	26
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Cases—Continued: Page

Bernstein v. *Capitol Care, Inc.*, 70 F.3d 783 (4th Cir. 1995) 9
Bill Gray Enters., Inc. Employee Health & Welfare Plan v. *Gourley*, 248 F.3d 206 (3d Cir. 2001) 28
Block v. *Pitney Bowes Inc.*, 952 F.2d 1450 (D.C. Cir. 1992) 14
Bowen v. *Yuckert*, 482 U.S. 137 (1987) 23
City of Milwaukee v. *Illinois*, 451 U.S. 304 (1981) 12
Cleveland v. *Policy Mgmt. Sys. Corp.*, 526 U.S. 795 (1999) 23
Connors v. *Connecticut Gen. Life Ins. Co.*, 272 F.3d 127 (2d Cir. 2001) 15-16
Conradt v. *Mt. Carmel Sch.*, 539 N.W.2d 713 (Wis. Ct. App. 1995) 26
Curtis-Wright v. *Schoonejongen*, 514 U.S. 73 (1995) 12
Davolt v. *Executive Comm. of O'Reilly Auto.*, 206 F.3d 806 (8th Cir. 2000) 28
DeFelice v. *American Int'l Life Assurance Co.*, 112 F.3d 61 (2d Cir. 1997) 18
Dickerson v. *Zurko*, 527 U.S. 150 (1999) 19
Dillon v. *Whirlpool Corp.*, 19 P.3d 951 (Or. Ct. App. 2001) 26
Doe v. *Group Hospitalization & Med. Servs.*, 3 F.3d 80 (4th Cir. 1993) 28
Doe v. *Travelers Ins. Co.*, 167 F.3d 53 (1st Cir. 1999) 18
Doyle v. *Public Employee's Ret. Sys.*, 808 So. 2d 902 (Miss. 2002) 26
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Firestone Tire & Rubber Co. v. *Bruch*, 489 U.S. 101 (1989) ..... *passim*
Geier v. *American Honda Motor Co.*, 529 U.S. 861 (2000) 12

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Hackett v. *Xerox Corp. Long-Term Disability Income Plan*, 315 F.3d 771 (7th Cir. 2003) 17
Hall v. *Unum Life Ins.*, 300 F.3d 1197 (10th Cir. 2002) 18
Halpin v. *W.W. Grainger, Inc.*, 962 F.2d 685 (7th Cir. 1992) 16
Heckler v. *Campbell*, 461 U.S. 458 (1983) 23
Hughes Aircraft Co. v. *Jacobson*, 525 U.S. 432 (1999) 12
Inter-Modal Rail Employees Ass'n v. *Atchison, Topeka & Santa Fe Ry.*, 520 U.S. 510 (1999) 12
Irish v. *McCall*, 747 N.Y.S.2d 610 (App. Div. 2002) 27
Jebian v. *Hewlett Packard Co. Employee Benefits Org. Income Protection Plan*, 310 F.3d 1173 (9th Cir. 2002) 14
Kimber v. *Thiokol Corp.*, 196 F.3d 1092 (10th Cir. 1999) 28
Kinstler v. *First Reliance Standard Life Ins. Co.*, 181 F.3d 243 (2d Cir. 1999) 18
Kreiger v. *Gold Bond Bldg. Prods.*, 868 F.2d 1091 (2d Cir. 1988) 19
Leahy v. *Raytheon Co.*, 315 F.3d 11 (1st Cir. 2002) 14
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Lockheed Corp. v. *Spink*, 517 U.S. 882 (1996) 12
Luby v. *Teamsters Healh, Welfare & Pension Trust Funds*, 944 F.2d 1176 (3d Cir. 1991) 18
McClanahan v. *Raleys Inc.*, 34 P.3d 573 (Nev. 2001) 26

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Morgan v. *Commissioner of Soc. Sec. Admin.*, 169 F.3d 595 (9th Cir. 1999) 8
National Mining Ass'n v. *Department of Labor*, 292 F.3d 849 (D.C. Cir. 2002) 24, 25
New York State Conference of Blue Cross & Blue Shield Plans v. *Travelers Ins. Co.*, 514 U.S. 645 (1995) 8-9
Pagan v. *Secretary of Health & Human Servs.*, 819 F.2d 1 (1st Cir. 1987) 20
Peruzzi v. *Summa Med. Plan*, 137 F.3d 431 (6th Cir. 1998) 28
Pierre v. *Connecticut Gen. Life Ins. Co.*, 932 F.2d 1552 (5th Cir.), cert. denied, 502 U.S. 973 (1991) 18
Pietrunti v. *Director, OWCP*, 119 F.3d 1035 (2d Cir. 1997) 24
Pilot Life Ins. Co. v. *Dedeaux*, 481 U.S. 41 (1987) 11
Pinto v. *Reliance Standard Life Ins. Co.*, 214 F.3d 377 (3d Cir. 2000) 28
Quesinberry v. *Life Ins. Co. of N. Am.*, 987 F.2d 1017 (4th Cir. 1993) 18
Ramsey v. *Hercules, Inc.*, 77 F.3d 199 (7th Cir. 1996) 18
Ratliff v. *Governor's Highway Safety Program*, 791 F.2d 394 (5th Cir. 1986) 19
Reeves v. *Sanderson Plumbing Prods., Inc.*, 530 U.S. 133 (2000) 13
Regula v. *Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), petition for cert. pending, No. 01-1840 ..... 5, 8, 15, 23
Reinking v. *Philadelphia Am. Life Ins. Co.*, 910 F.2d 1210 (4th Cir. 1990), overruled on other grounds by *Quesinberry* v. *Life Ins. Co. of N. Am.*, 987 F.2d 1017 (4th Cir. 1993) 19
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Rowan v. *Unum Life Ins. Co.*, 119 F.3d 433 (6th Cir. 1997) 18
Schisler v. *Sullivan*, 3 F.3d 563 (2d Cir. 1993) 22
Schweiker v. *Chilicky*, 487 U.S. 412 (1988) 23
Shaw v. *Delta Air Lines, Inc.*, 463 U.S. 85 (1983) 9
Stephens v. *Heckler*, 766 F.2d 284 (7th Cir. 1985) 20
Tennant v. *Peoria & Pekin Union Ry.*, 321 U.S. 29 (1944) 13
Tremain v. *Bell Indus., Inc.*, 196 F.3d 970 (9th Cir. 1999) 5
United Postal Serv. Bd. of Governors v. *Aikens*, 460 U.S. 711 (1983) 13
United States v. *United States Gypsum Co.*, 333 U.S. 364 (1948) 19
Varity Corp. v. *Howe*, 516 U.S. 489 (1996) 12, 13
Walker v. *American Home Shield Long Term Disability Plan*, 180 F.3d 1065 (9th Cir. 1999) 18
White v. *Principi*, 243 F.3d 1378 (Fed. Cir. 2001) 25
Yochum v. *Barnett Banks, Inc. Severance Pay Plan*, 234 F.3d 541 (11th Cir. 2000) 28
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Tit. I, 29 U.S.C. 1001 *et seq.* 1
29 U.S.C. 1002(21)(A) 12
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29 U.S.C. 1132(a)(1)(B) (§ 502(a)(1)(B)) 3, 15
29 U.S.C. 1133 17
29 U.S.C. 1133(1) 6, 9, 16

Statutes, regulations and rule—Continued: Page

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Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 901 *et seq.* 24
Railroad Retirement Act of 1974, 45 U.S.C. 231 *et seq.* 25
Social Security Act, 42 U.S.C. 301 *et seq.* 5, 20, 23, 24
Tit. II, 42 U.S.C. 401 *et seq.*:
42 U.S.C. 405(a) 23
42 U.S.C. 405(g) 20
Tit. XVI, 42 U.S.C. 1381 *et seq.* 21
5 U.S.C. 706 19
38 U.S.C. 7104(a) 25
20 C.F.R.:
Section 404.1502 21
Section 404.1527 21
Section 404.1527(d)(2) 21, 22
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Section 404.1527(d)(3)-(d)(5) 22
Section 416.927 21
Section 718.104(d)(5) 25
29 C.F.R.:
Section 2560.503-1 ..... 1, 6, 7, 9
Section 2560.503-1 (2000) 9
Section 2560.503-1(f)(1) (2000) 10
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Section 2560.503-1(g)(1) (2000) 10
Section 2560.503-1(g)(1)(i) 10, 16
Section 2560.503-1(g)(1)(ii) 10
Section 2560.503-1(g)(1)(v)(B) 11
Section 2560.503-1(h)(1) 10, 16
Section 2560.503-1(h)(2)(iv) 10, 16
Section 2560.503-1(h)(3) (2000) 10
Section 2560.503-1(h)(3)(iii) 10, 29
Section 2560.503-1(h)(4) 10
Section 2560.503-1(j)(1) 10, 16
Section 2560.503-1(j)(2) 10
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Section 2560.503-1(o) 9
Fed. R. Civ. P. 52(a) 18

Miscellaneous: Page

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p. 13,014 21
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p. 70,246 ..... 9, 11
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Restatement (Second) of Trusts (1959) 13-14, 28

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INTEREST OF THE UNITED STATES

This case presents the question whether the administrator of a disability plan covered by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, is required, when deciding whether a claimant is disabled, to give special weight to the opinion of the claimant's treating physician. The Secretary of Labor has primary authority for the enforcement and interpretation of Title I of ERISA, and in that connection has issued regulations governing the procedures to be followed by plans in the processing of claims for benefits. 29 C.F.R. 2560.503-1.

STATEMENT

1. Petitioner Black & Decker Disability Plan (the plan) is an ERISA-governed employee welfare benefit plan that provides disability benefits to employees of Black and Decker Corporation (Black & Decker) and certain of its subsidiaries. Pet. App. 2-3. Black & Decker is the funding source for the plan and acts as plan administrator, although it has dele-

gated the authority to make initial determinations on claims to a third-party administrator, Metropolitan Life Insurance Company (MetLife). *Id.* at 3-6, 8-9. The plan provides benefits for eligible employees with a "disability," which the plan defines as "the complete inability * * * of a Participant to engage in his regular occupation with the Employer (during the first 30 months of Disability)." *Id.* at 3 n.2. The plan thereafter grants benefits if the employee has a "complete inability * * * to engage in any gainful occupation or employment * * * for which the Employee is * * * reasonably qualified by education, training, or experience." *Ibid.* The plan provides that a disability determination "shall be made by the Plan Manager based on suitable medical evidence and a review of the Participant's employment history that the Plan Manager deems satisfactory in its sole and absolute discretion." *Id.* at 3 n.1.

Respondent filed a claim in July 1997 for disability benefits under the plan. During the plan's consideration of his claim, respondent submitted reports from physicians who treated him beginning in March 1997, stating that he suffered from degenerative disc disease and was unable to perform certain functions required in his regular job as a material planner. Pet. App. 2-4; *id.* at 19-23 (describing respondent's course of treatment). MetLife denied the claim, and respondent sought review of that ruling. *Id.* at 5.

During the review process, petitioner referred respondent to a neurologist, Dr. Mitri, who examined respondent and concluded that, although he was suffering from disc disease, he was capable of performing a sedentary job. Pet. App. 5, 23-24. In addition, at the request of respondent's counsel, a Black & Decker human resources representative completed a work capacity evaluation form in which she gave an affirmative answer to the question whether, assuming that respondent faced chronic myofascial pain that would interfere with necessary interpersonal communications and his

ability to react appropriately to stress, respondent lacked the capacity to perform his job. *Id.* at 5, 34 n.2. MetLife thereafter made a final recommendation to the plan manager to deny the claim. *Id.* at 5.

On October 27, 1998, an employee in Black & Decker's Corporate Benefits department wrote respondent's counsel informing him that petitioner was upholding the denial of benefits. Pet. App. 5-6. The letter stated that "[w]e have thoroughly reviewed all the medical and vocational information in our possession." C.A. Supp. E.R. 166. The letter summarized the conclusions of respondent's treating physicians regarding his limitations; the results of x-rays, MRIs, and other diagnostic tests; and the opinion of Dr. Mitri based on his review of the tests and his independent examination of respondent. The letter also recounted that Dr. Mitri's report had been forwarded to respondent's counsel with a request to provide the comments of his treating physicians, but that respondent had provided no new or different information that would change the original decision. Finally, the letter explained that the work capacity evaluation completed by Black & Decker's human resource representative was insufficient to reverse the decision that respondent was not disabled. The letter concluded: "Based on our review, the medical evaluation supports [respondent's] ability to return to work at his own occupation, and therefore, he cannot be considered disabled as defined by the Black & Decker Disability Plan." *Id.* at 167.

2. Respondent then filed this action in federal district court under Section 502(a)(1)(B) of ERISA, 29 U.S.C. 1132(a)(1)(B), seeking to recover benefits under the plan. On the parties' cross-motions for summary judgment, the court granted judgment in favor of the plan. Pet. App. 18-36.

In addressing the applicable standard of judicial review, the district court noted that the plan gives its administrator discretion to determine benefits eligibility and that the

administrator's decision to deny benefits therefore would ordinarily be reviewed for abuse of discretion in accordance with *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U.S. 101, 111-112 (1989). In addition, the court concluded that respondent had not adduced sufficient evidence that the conflict of interest resulting from the fact that Black & Decker both funds the plan and decides benefits claims under it had actually led to a breach of fiduciary duty that would warrant de novo rather than abuse-of-discretion review under Ninth Circuit precedent. Pet. App. 30-32. Under the latter test, the court observed, "[i]t is an abuse of discretion for an ERISA plan administrator to make a decision without any explanation, or in a way that conflicts with the plain language of the plan, or that is based on clearly erroneous findings of fact." *Id.* at 32 (quoting *Atwood* v. *Newmont Gold Co.*, 45 F.3d 1317, 1323-1324 (9th Cir. 1995)). The court found no such error by the plan administrator. *Id.* at 31-32.

The district court reasoned that the administrator's finding of no disability was not improper simply because it was contradicted by some evidence in the record. Pet. App. 33. Consequently, the court explained, the opinion of Black & Decker's human resources representative, who lacked expertise in medicine or vocational evaluation, did not suffice to overturn the administrator's conclusion that respondent was not disabled, given the other evidence in the record before the administrator. *Id.* at 33-34. The court further concluded that the plan administrator was not required to credit the opinion of respondent's treating physicians over the opinion of an independent medical examiner, especially since petitioner gave respondent's treating physicians an opportunity to comment on the independent examiner's opinion and respondent apparently never took advantage of that opportunity. *Id.* at 34-35.

3. The court of appeals reversed. Pet. App. 1-16. It first explained that, where a plan clearly confers discretion on the

plan administrator to determine eligibility, an administrator like Black & Decker, which also acts as funding source for the plan, has an "inherent conflict of interest" that warrants review that is "still for abuse of discretion, [but it] is less deferential." *Id.* at 8 (quoting *Tremain* v. *Bell Indus., Inc.*, 196 F.3d 970, 976 (9th Cir. 1999)). The court further explained, however, that, if the plan beneficiary provides "material, probative evidence" that the administrator's self-interest actually caused a breach of the administrator's fiduciary obligations to the beneficiary, then the court applies a de novo standard of review, unless the plan in rebuttal produces evidence to show that the conflict did not affect the decision to deny benefits. *Id.* at 9-10.

Applying that framework, the court of appeals concluded (Pet. App. 10) that its decision was "controlled" by its earlier decision of *Regula* v. *Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), petition for cert. pending, No. 01-1840. Pet. App. 10-12. In *Regula*, a divided panel held that a "treating physician rule" used in making and reviewing disability determinations under the Social Security Act, 42 U.S.C. 301 *et seq.*, also applies to disability determinations under benefit plans governed by ERISA. 266 F.3d at 1138-1144. As described by the court in *Regula*, the treating physician rule requires a plan administrator "who rejects [the treating physician's] opinions to come forward with specific reasons for his decision, based on substantial evidence in the record." *Id.* at 1139. The court in *Regula* also held that where a plan administrator also funds the plan, the administrator's deviation from the treating physician rule may furnish a basis for concluding that the apparent conflict of interest that results from the administrator's dual status had ripened into an "actual, serious conflict," thereby triggering de novo review of the benefit denial. *Id.* at 1147. In this case, the court of appeals found no reasons in the record "as to why the treating physicians' opinions were

unreliable and Dr. Mitri's more reliable." Pet. App. 13. It therefore concluded that petitioner's lack of explanation sufficed to show that it breached its fiduciary duty due to a conflict of interest, which in turn warranted the court's exercise of de novo review. *Id.* at 14-15.[1]

Applying a de novo standard, the court of appeals concluded that the only evidence contradicting respondent's claim of disability—Dr. Mitri's opinion—could not reasonably overcome all the other evidence that it regarded as establishing disability. Pet. App. 15. In the court's view, "no reasonable trier of fact could conclude that [respondent] is not disabled," and it therefore held that he is entitled to benefits under the plan for his first 30 months of disability. *Id.* at 15-16.

SUMMARY OF ARGUMENT

A. Nothing in ERISA or the Secretary of Labor's regulations mandates that a plan administrator give special weight to the opinions of a claimant's treating physician when rendering a benefits determination. Rather, the Act and regulations require plans to have procedures that provide for the "full and fair review" of claims and to provide participants with the "specific reasons" for any decision denying benefits. 29 U.S.C. 1133(1) and (2); 29 C.F.R. 2560.503-1. Those provisions do not purport to cabin a plan administrator's discretion in weighing conflicting medical evidence in determining a claimant's entitlement to benefits under the terms of a welfare benefits plan.

In the absence of a regulation requiring a treating physician rule, courts should not impose such a rule under their authority to fashion a "federal common law" under ERISA.

[1] The court of appeals also concluded that the plan administrator's rejection of the view of Black & Decker's human resources representative that claimant could not perform his past work was "some evidence" of a conflict of interest. Pet. App. 11.

Firestone, 489 U.S. at 110. Such a rule would unduly interfere with the ability of employers to establish and design plans that confer on plan administrators the discretion to weigh conflicting evidence. Moreover, a treating physician rule is not necessary to guard against arbitrary decision-making by plan administrators, as courts may review plan administrators' decisions to determine whether the administrator acted unreasonably in disregarding evidence of a claimant's disability, including the opinions of treating physicians. Courts also may review plan administrators' actions to determine whether they comply with the statutory and regulatory requirements of full and fair review and of providing specific reasons for a denial of benefits.

B. Nor does the special treating physician rule applicable under the Social Security disability program furnish a basis for judicial imposition of a similar rule under ERISA. That rule was adopted by the Commissioner of Social Security in regulations issued in 1991, to bring nationwide uniformity to a vast statutory benefits program and in light of varying court of appeals decisions addressing the question. ERISA, by contrast, governs a broad range of private benefit plans to which both the statute and implementing regulations issued by the Secretary of Labor permit significant flexibility in the processing of claims. Moreover, the Social Security Act's treating physician rule has not been uniformly or generally applied even under *statutory* disability programs other than Social Security.

ARGUMENT

A "TREATING PHYSICIAN RULE" SHOULD NOT BE APPLIED BY COURTS IN REVIEWING DISABILITY DETERMINATIONS UNDER PLANS COVERED BY ERISA

The Ninth Circuit, following its earlier decision in *Regula*, held that the "treating physician rule" applicable to Social

Security disability determinations governs a plan administrator's disability determination under employee benefits plans covered by ERISA. The Ninth Circuit stated in *Regula* that "[t]he treating physician rule applied in the Social Security setting requires that the administrative law judge ('ALJ') determining the claimant's eligibility for benefits give deference to the opinions of the claimant's treating physician, because 'he is employed to cure and has a greater opportunity to know and observe the patient as an individual.'" 266 F.3d at 1139 (quoting *Morgan* v. *Commissioner of Soc. Sec. Admin.*, 169 F.3d 595, 600 (9th Cir. 1999)). "This grant of deference," the Ninth Circuit reasoned, "increases the accuracy of disability determinations by forcing the ALJ who rejects those opinions to come forward with specific reasons for his decision, based on substantial evidence in the record." *Ibid.* Based on what it regarded as "common sense" as well as an interest in "consistency in [judicial] review of disability determinations where benefits are protected by federal law," the Ninth Circuit saw "no reason why the treating physician rule should not be used under ERISA in order to test the reasonableness of the administrator's positions." *Ibid.* That analysis was erroneous.

A. A Treating Physician Rule Is Inappropriate And Unnecessary Under ERISA

1. ERISA is a comprehensive statute designed "to promote the interests of employees and their beneficiaries in employee benefit plans," and "to protect contractually defined benefits." *Firestone*, 489 U.S. at 113 (internal quotation marks and citation omitted). The statute "does not go about protecting plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits," but rather protects their interests by, among other things, setting standards of reporting, disclosure, and fiduciary responsibility for plan administrators, and by providing a comprehensive civil enforcement scheme. *New*

York State Conference of Blue Cross & Blue Shield Plans v. *Travelers Ins. Co.*, 514 U.S. 645, 651 (1995); accord *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983).

ERISA also requires certain plan procedures for the internal resolution of claims. ERISA requires that, "[i]n accordance with regulations of the Secretary, every employee benefit plan shall * * * provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." 29 U.S.C. 1133(1). ERISA further requires that, again "[i]n accordance with regulations of the Secretary," plans must "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. 1133(2). Congress's purpose in enacting those provisions was to "promot[e] internal resolution of claims and encourag[e] informal and non-adversarial proceedings under ERISA." *Bernstein* v. *CapitalCare, Inc.*, 70 F.3d 783, 788-789 (4th Cir. 1995); accord *Lindemann* v. *Mobil Oil Corp.*, 79 F.3d 647, 650 (7th Cir. 1996); *Grossmuller* v. *International Union, United Auto Workers, Local 813*, 715 F.2d 853, 857 (3d Cir. 1983).

Consistent with these principles, the Secretary of Labor has issued regulations that govern the consideration and determination of a claim for benefits under a plan. 29 C.F.R. 2560.503-1. Revisions to those regulations were issued in November 2000, 65 Fed. Reg. 70,246, and became effective for claims filed on or after January 1, 2002. 29 C.F.R. 2560-503-1(o).[2] The regulations have at all times required every

[2] Because respondent sought benefits under the plan before the effective date of the new regulations, the Department's prior regulation, 29 C.F.R. 2560.503-1 (2000), applies in this case.

benefit plan to establish and maintain a procedure "under which there will be a full and fair review of the claim." 29 C.F.R. 2560.503-1(h)(1); accord 29 C.F.R. 2560.503-1(g)(1) (2000). The new regulations further specify that a plan's claims procedures must "[p]rovide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim." 29 C.F.R. 2560.503-1(h)(2)(iv). In addition, the new regulations require group health and disability plans to provide that, "in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment," the administrator "shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment." 29 C.F.R. 2560.503-1(h)(3)(iii) and (4); see also Pension and Welfare Benefits Admin. (PWBA), Dep't of Labor, *Benefits Claims Procedure Regulation*, Question D-8 (Sept. 4, 2002) <http://www.dol.gov/ebsa/FAQs/faq_claims_proc_reg. html> (*reprinted in* Pet. App. 77) ("In all cases, a fiduciary must take appropriate steps to resolve the appeal in a prudent manner, including acquiring necessary information and advice, weighing the advice and information so obtained, and making an independent decision on the appeal.").

The regulations have at all times required that a plan administrator's final decision provide, in a manner calculated to be understood by the claimant, the "specific reason or reasons for the adverse determination" as well as specific references to the plan provisions on which the denial is based. 29 C.F.R. 2560.503-1(j)(1) and (2); 29 C.F.R. 2560.503-1(h)(3) (2000); accord 29 C.F.R. 2560.503-1(g)(1)(i) and (ii) (parallel requirements for initial decision on claim); 29 C.F.R. 2560.503-1(f)(1) and (2) (2000) (same). The new regulations additionally require, for certain determinations by group health plans and plans providing disability benefits, that the notice include either an "explanation of the scientific or

clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances," or a statement that such explanation will be provided on request. 29 C.F.R. 2560.503-1(j)(5)(ii); 29 C.F.R. 2560.503-1(g)(1)(v)(B).

Nothing in those regulatory provisions suggests that plan administrators must accord special deference to the opinions of treating physicians in considering a participant's entitlement to benefits under the plan or must explain why no such deference was given. Indeed, "[t]he [D]epartment did not intend to prescribe any particular process or safeguard to ensure and verify consistent decision making by plans. To the contrary, the [D]epartment intended to preserve the greatest flexibility possible for * * * operating claims processing systems consistent with the prudent administration of a plan." PWBA, Dep't of Labor, *Benefits Claims Procedure Regulation*, Question B-4 (*reprinted in* Pet. App. 52). The regulations thus reflect the Department's considered view that an informal and flexible system of claims processing best "reconcile[s] the need for procedural protections with the purely voluntary nature of the system through which these vital benefits are delivered." 65 Fed. Reg. at 70,246.

2. The absence of any requirement in ERISA itself or in the Secretary's implementing regulations that plan administrators accord special weight to opinions of treating physicians counsels strongly against courts adopting such a requirement on their own. Although courts have authority "to develop a 'federal common law of rights and obligations under ERISA-regulated plans,'" *Firestone*, 489 U.S. at 110 (quoting *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 56 (1987)), they should be particularly cautious in invoking that authority to impose special rules governing a particular subject matter when Congress has committed that subject matter (here, the review of benefit claims) to the primary jurisdiction of the Secretary, and the Secretary in turn has

imposed certain specific requirements but otherwise intentionally preserved broad flexibility for employers and others who design these private benefits plans and process claims under them. Compare *City of Milwaukee* v. *Illinois*, 451 U.S. 304 (1981); cf. *Geier* v. *American Honda Motor Co.*, 529 U.S. 861, 874-875, 881- 884 (2000).

More broadly, "[e]mployers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans." *Hughes Aircraft Co.* v. *Jacobson*, 525 U.S. 432, 443 (1999) (quoting *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 890 (1996)); accord *Inter-Modal Rail Employees Ass'n* v. *Atchison, Topeka & Santa Fe Ry.*, 520 U.S. 510, 515 (1997); *Curtis-Wright Corp.* v. *Schoonejongen*, 514 U.S. 73, 78 (1995). Accordingly, quite aside from the Secretary's claims processing regulations that apply in this particular context, ERISA generally leaves to the employer decisions "regarding the form or structure of the Plan such as who is entitled to receive Plan benefits and in what amounts, or how such benefits are calculated." *Hughes Aircraft Co.*, 525 U.S. at 444. It follows that, in fashioning federal common law under ERISA, "courts may have to take account of competing congressional purposes, such as Congress' desire to offer employees enhanced protection for their benefits, on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp.* v. *Howe*, 516 U.S. 489, 497 (1996).

To be sure, once an employer establishes a plan covered by ERISA, plan administrators are fiduciaries, 29 U.S.C. 1002(21)(A), and must administer the plan consistent with their duties of prudence and loyalty. 29 U.S.C. 1104(a). But nothing in the common law of trusts requires plan administrators, in making factual determinations, to give special weight or deferential consideration to particular evidence

submitted by a beneficiary who seeks benefits under the plan. To the contrary, under ERISA the administrator's fiduciary duty runs to the plan as a whole, and the fiduciary's duty is to follow the terms of the plan and render correct decisions under it, carefully weighing all of the relevant evidence. 29 U.S.C. 1104(a)(1)(D); *Varity Corp.*, 516 U.S. at 513-514. Indeed, any rule requiring the fiduciary always to give special weight to the opinion of a beneficiary's treating physician would run counter to the background rule—which should not be displaced in the absence of strong reasons—that a finder of fact "should consider all the evidence, giving it whatever weight and credence it deserves." *United Postal Serv. Bd. of Governors* v. *Aikens*, 460 U.S. 711, 714 n.3 (1983); accord *Reeves* v. *Sanderson Plumbing Prods., Inc.*, 520 U.S. 133, 150 (2000) (factfinder's function includes "[c]redibility determinations, the weighing of the evidence, and the drawing of legitimate inferences from the facts.") (quoting *Anderson* v. *Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986)); cf. *Tennant* v. *Peoria & Pekin Union Ry.*, 321 U.S. 29, 35 (1944) ("The very essence of [the jury's] function is to select from among conflicting inferences and conclusions that which it considers most reasonable.").

It is significant as well that employers are free under ERISA to design plans that grant discretion to the plan administrator to interpret plan terms and make eligibility determinations consistent with the administrator's fiduciary duties and the Act. *Firestone*, 489 U.S. at 111-115. A plan that confers discretion on the administrator to determine whether a claimant is disabled necessarily leaves to the administrator the discretion to resolve factual disputes, such as the nature and extent of the claimant's medical condition and physical limitations. In such instances, the administrator's determinations are reviewed deferentially by a court, *ibid.*, and are not subject to reversal "except to prevent an abuse * * * of * * * discretion." Restatement (Second) of

Trusts § 187 (1959) (cited with approval in *Firestone*, 489 U.S. at 111). Accordingly, in reviewing a plan administrator's decision that a participant is not disabled, "[t]he essential inquiry" for a court is whether the administrator "reasonably construe[d] and appl[ied] the * * * Plan in [the claimant's] case." *Block* v. *Pitney Bowes Inc.*, 952 F.2d 1450, 1454 (D.C. Cir. 1992) (R.B. Ginsburg, J.); accord *Leahy* v. *Raytheon Co.*, 315 F.3d 11, 17 (1st Cir. 2002) (an arbitrary and capricious standard "asks only whether a factfinder's decision is plausible in light of the record as a whole, * * * or, put another way, whether the decision is supported by substantial evidence in the record" (citations omitted)); Restatement (Second) of Trusts § 187, cmt. i, illus. 9 (1959) (trustee's decision on whether beneficiary is competent must be upheld "[i]f * * * reasonable men might differ on the question").[3]

Where an employer designs a plan that gives the plan administrator discretionary authority to weigh conflicting evidence, "[a] rule that requires plan administrators to consider certain types of evidence and to weigh that evidence in

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[3] As then-Judge Ginsburg explained in *Block*:

> The distinction, if any, between "arbitrary and capricious review" and review for "abuse of discretion" is subtle. *Cf. Ass'n of Data Processing Service Organizations, Inc.* v. *Board of Governors of Federal Reserve System*, 745 F.2d 677, 684 (D.C. Cir. 1984) (Scalia, J.) (distinction between substantial evidence test and arbitrary or capricious test is "'largely semantic'") (citations omitted). In the matter at hand, we are satisfied, there is no need to adopt one phrase and avoid the other. The reasonableness of the Plan Committee's decision is our polestar, as commentary relating to Administrative Procedure Act analogs almost uniformly affirms.

952 F.2d at 1454; accord; *Leahy* v. *Raytheon Co.*, 315 F.2d at 15 n.3; *Jebian* v. *Hewlett Packard Co. Employee Benefits Org. Income Protection Plan*, 310 F.3d 1173, 1177 (9th Cir. 2002); *Meditrust Fin. Servs. Corp.* v. *Sterling Chems., Inc.*, 168 F.3d 211, 214 (5th Cir. 1989); *Anderson* v. *Blue Cross/Blue Shield*, 907 F.2d 1072, 1075 n.2 (11th Cir. 1990).

a compulsory manner would effectively undermine that discretion." *Regula*, 266 F.3d at 1151 (Brunetti, J., dissenting). Likewise, if a review of the administrator's decision reveals that the administrator reasonably declined to defer to the opinion of a treating physician, the decision is not arbitrary simply because the decision failed to rebut the opinion with "specific, legitimate reasons." Pet. App. 13. For instance, the treating physician's opinion on its face may reveal why the administrator reasonably gave it little or no weight—*e.g.*, the opinion may not be accompanied or supported by objective or clinical findings, or the physician may have lacked relevant expertise. Cf. *id.* at 11 (rejecting respondent's contention that the administrator should have provided "specific reasons" for rejecting the opinion of petitioner's human resource representative, because the administrator "was under no duty to rebut with specificity all evidence adduced by [respondent] to support his claim"). Likewise, the reasons that an administrator did not rely on the treating physician's opinion may reasonably be apparent from other medical evidence, laboratory tests, or examinations, as well as non-medical evidence, that rebut the opinion of the treating physician regarding the claimant's condition or limitations.

3. The absence of a rule under ERISA that special weight be given to the opinion of the beneficiary's treating physician does not mean that plan administrators may arbitrarily disregard such opinions—or, for that matter, that they may disregard any other reliable evidence that bears on an entitlement to benefits under the plan. If a plan denies a claim for benefits, the beneficiary may challenge that action under 29 U.S.C. 1132(a)(1)(B). Even under a deferential standard of review, a court may determine in a particular case that the decision-maker's disregard of the opinion of the claimant's treating physician (or other material evidence) constituted an abuse of discretion. Cf. *Connors* v. *Connecti-*

cut Gen. Life Ins. Co., 272 F.3d 127, 135-136 (2d Cir. 2001) (district court, on de novo review of administrator's decision, clearly erred in rejecting treating physician's opinion because district court erroneously believed that participant had been referred to physician by his attorney when physician, in fact, had been participant's treating physician for several years).

The Act and regulations provide other significant protections for plan participants and beneficiaries as well. As discussed above, plan procedures must provide for a "full and fair review" of a denial of a claim for benefits (29 U.S.C. 1133(2); 29 C.F.R. 2560.503-1(h)(1)), and such a review must "take[] into account all comments, documents, records, and other information submitted by the claimant relating to the claim" (29 C.F.R. 2560.503-1(h)(2)(iv)). The plan administrator's decision must also provide the "specific reasons" for any adverse determination (29 U.S.C. 1133(1); 29 C.F.R. 2560.503-1(g)(1)(i) and (j)(1)), and the beneficiary must be furnished, or afforded the right to obtain, an "explanation of the scientific or clinical judgment" for certain determinations by group health and disability plans (29 C.F.R. 2560.503-1(j)(5)(ii)).

Under those provisions, "the persistent core requirements of review intended to be full and fair include knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of that evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision." *Grossmuller*, 715 F.2d at 858 n.5. The purpose of requiring specific reasons for an administrator's denial of benefits is "to afford the beneficiary and the courts a sufficiently precise understanding of the ground for the denial to permit a realistic possibility of review, even under a deferential standard." *Halpin* v. *W.W. Grainger, Inc.*, 962 F.2d 685, 694 (7th Cir. 1992). Thus, in an appropriate case, a

plan administrator's failure to adequately address the well-reasoned and documented opinion of a physician may violate ERISA and the Secretary's regulations. *E.g.*, *Hackett* v. *Xerox Corp. Long-Term Disability Income Plan*, 315 F.3d 771, 774-775 & n.3 (7th Cir. 2003) (reversing administrator's decision for failing to provide adequate reasons for terminating disability benefits that plan had been paying for twelve years, where termination was based on one physician's opinion that failed to provide "[a]ny non-arbitrary explanation" why his opinion differed from that of several previous doctors).[4] Finally, where, as here, the plan administrator both funds the plan and renders decisions on claims for benefits under it, more searching scrutiny of the administrator's denial of a claim is warranted. *Firestone*, 489 U.S. at 115; p. 27, *infra*. In those circumstances, there may be special justification for expecting the administrator to explain his consideration of material evidence submitted by the claimant.

4. The above principles also counsel against adoption of a special "treating physician rule" even where a plan, in the exceptional case after *Firestone*, does not confer discretion on the plan administrator to resolve factual questions and the district court's review of the administrator's decision

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[4] Respondent did not argue in his briefs in the court of appeals, or in his brief in opposition to the certiorari petition, that the plan administrator's decision in this case failed to comply with 29 U.S.C. 1133 or the Department's regulations because of any inadequacies in its explanation concerning the opinions of treating physicians. Compare Pet. App. 11-12 n.7 (rejecting contention that administrator was required to provide "specific reasons for rejecting the opinion" of petitioner's human resource representative). Respondent relied only on the judge-made treating physician rule. For that reason, and because new regulations are now in effect, this brief does not address whether the administrator's decision satisfied 29 U.S.C. 1133 and the regulations that applied at the time.

therefore is de novo under *Firestone*, 489 U.S. at 111-115.[5] In that situation, the district court is charged with interpreting the relevant terms of the plan and determining the claimant's entitlement to benefits, typically based on the record before the administrator.[6] The district court thus performs essentially the same function as the plan administrator, weighing the reports of the physicians who have treated or examined the claimant or reviewed his records, as well as any other relevant evidence in the record. Compare *Richardson* v. *Perales*, 402 U.S. 389 (1971) (upholding Social Security hearing examiner's reliance on written medical reports, without requiring physicians to testify). In the absence of any plan term that requires deference to the opinion of a treating physician, the district court would not be automatically required to give special weight to such an opinion.

On appeal of a district court's decision in such a case, any factual findings by the district court presumably must be upheld under Federal Rule of Civil Procedure 52(a) unless they are clearly erroneous, *i.e.* "the reviewing court on the

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[5] The courts of appeals generally agree that in such circumstances the administrator's factual findings are reviewed de novo. *Riedl* v. *General Am. Life Ins. Co.*, 248 F.3d 753, 756 (8th Cir. 2001); *Kinstler* v. *First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 249-251 (2d Cir. 1999); *Walker* v. *American Home Shield Long Term Disability Plan*, 180 F.3d 1065, 1069 (9th Cir. 1999); *Rowan* v. *Unum Life Ins. Co.*, 119 F.3d 433, 435 (6th Cir. 1997); *Ramsey* v. *Hercules, Inc.*, 77 F.3d 199, 203-205 (7th Cir. 1996); *Luby* v. *Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1183 (3d Cir. 1991); *Reinking* v. *Philadelphia Am. Life Ins. Co.*, 910 F.2d 1210, 1213-1214 (4th Cir. 1990), overruled on other grounds by *Quesinberry* v. *Life Ins. Co. of N. Am.*, 987 F.2d 1017 (4th Cir. 1993); but see *Pierre* v. *Connecticut Gen. Life Ins. Co.*, 932 F.2d 1552, 1557-1562 (5th Cir.), cert. denied, 502 U.S. 973 (1991).

[6] *Hall* v. *Unum Life Ins.*, 300 F.3d 1197, 1202 (10th Cir. 2002); *Doe* v. *Travelers Ins. Co.*, 167 F.3d 53, 57-58 (1st Cir. 1999); *DeFelice* v. *American Int'l Life Assurance Co.*, 112 F.3d 61, 65 (2d Cir. 1997).

entire evidence is left with the definite and firm conviction that a mistake has been committed." *United States* v. *United States Gypsum Co.*, 333 U.S. 364, 395 (1948); cf. *Dickinson* v. *Zurko*, 527 U.S. 150, 153, 162-163 (1999) (observing that the clearly erroneous standard "has been considered somewhat stricter (*i.e.* allowing somewhat closer judicial review)" than the substantial evidence standard under 5 U.S.C. 706, "[b]ut the difference is a subtle one"). Any requirement by the courts of appeals that district courts categorically give special weight to the opinions of treating sources, but not other opinion evidence, would interfere with the traditional discretion of trial courts to weigh conflicting medical evidence. *Anderson* v. *City of Bessemer*, 470 U.S. 564, 573 (1985); *Zenith Radio Corp.* v. *Hazeltine Research, Inc.*, 395 U.S. 100, 123 (1969). Similarly, while the district court's findings must "permit intelligent appellate review," reviewing courts do not require either "'punctilious detail'" or "'slavish tracing of the claims issue by issue and witness by witness.'" *Krieger* v. *Gold Bond Bldg. Prods.*, 863 F.2d 1091, 1097 (2d Cir. 1988) (quoting *Ratliff* v. *Governor's Highway Safety Program*, 791 F.2d 394, 400 (5th Cir. 1986)).

B. Application Of A Treating Physician Rule Under The Social Security Act Does Not Justify Judicial Imposition Of Such A Rule Under ERISA

The court of appeals held that the special treating physician rule applied under the Social Security disability program warranted the fashioning of a parallel rule by the courts to govern private benefit plans under ERISA. The court of appeals overlooked the special circumstances that gave rise to the rule applied in the Social Security program and critical distinctions between that program and ERISA.

1. The Commissioner of Social Security adopted a treating physician rule in regulations issued in 1991 in response to judicial decisions that had developed similar rules in the course of reviewing disability determinations by ALJs who

had considered such opinion evidence. Prior to 1991, most courts of appeals generally held that the ALJ should give special weight to the claimant's treating physician as the medical expert with best opportunity to familiarize himself with the claimant's condition, although "significant variation exist[ed] * * * with regard to the treatment to be afforded to the treating physician's opinion and the evidence required to refute it." James A. Maccaro, *The Treating Physician Rule and the Adjudication of Claims for Social Security Disability Benefits*, 41 Soc. Sec. Rep. Serv. (West) 833, 834 (1993).

As the Commissioner explained when the regulations were promulgated, the appellate precedents requiring that special weight be given to the opinions of treating physicians did not hold that such a rule was required by the Social Security Act. 56 Fed. Reg. 36,932, 36,934 (1991). Rather, those precedents developed in the course of case-by-case review of individual ALJ decisions under the substantial evidence test required by 42 U.S.C. 405(g). Two courts of appeals, moreover, had specifically rejected the principle that a treating physician's opinion was necessarily entitled to special weight under the Social Security Act. *Pagan* v. *Secretary of Health & Human Servs.*, 819 F.2d 1, 3-4 (1st Cir. 1987) (opinion of treating physician "not entitled to greater weight" over the opinion of "a consulting physician"; "[i]t is the [agency's] province to resolve conflicts in the medical evidence"); *Stephens* v. *Heckler*, 766 F.2d 284, 289 (7th Cir. 1985) ("Experience and knowledge * * * lie on the side of the treating physician, expertise and knowledge of similar cases on the side of the consulting specialist. How these weigh in a particular case is a question for the [agency], subject only to the rule that the final decision must be supported by 'substantial evidence.'").

In 1991, the Commissioner concluded "that judicial decisions in several circuits pointed to a need for a clear policy

statement that would encourage uniformity of adjudication and provide the public and the courts with a definitive explanation of [the Commissioner's] policy on weighing treating source opinions." 56 Fed. Reg. at 36,934; see also 52 Fed. Reg. 13,014, 13,016 (1987) (proposing the regulations "in response to certain Federal Circuit Court of Appeals decisions"). The Commissioner accordingly promulgated regulations to resolve the controversy and furnish "detailed provisions that would prescribe rules stating how [the Commissioner] would consider and weigh medical opinions," including those from the claimant's treating source. 56 Fed. Reg. at 36,934.

The regulations define a "[t]reating source" as an "acceptable medical source who * * * has, or has had, an ongoing treatment relationship" with the claimant, 20 C.F.R. 404.1502, and set forth the standards for evaluating opinions from that source under 20 C.F.R. 404.1527.[7] The regulations provide that, in "[e]valuating opinion evidence," the Commissioner "[g]enerally [will] give more weight to opinions from * * * treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of [the claimant's] medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations." 20 C.F.R. 404.1527(d)(2). The Commissioner explained in issuing the regulations that, "[a]ll things being equal, * * * [the Commissioner] will always give greater weight to the treating source's opinion than to the opinions of nontreating sources." 56 Fed. Reg. at 36,936.

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[7] The Commissioner has promulgated a similar regulation, 20 C.F.R. 416.927, to govern disability determinations for indigent persons under the Supplemental Security Income Program in Title XVI of the Social Security Act.

The Commissioner will give the treating source's opinion on the nature and severity of a claimant's impairments "controlling weight" if it "is well-supported by medically accepted clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the claimant's] case record." 20 C.F.R. 404.1527(d)(2). Where the opinion is not given controlling weight, the Commissioner will consider other factors, including the "[l]ength of the treatment relationship and the frequency of examination," "[s]upportability," "[c]onsistency," and "[s]pecialization" of the treating source, "in determining the weight to give to the opinion." 20 C.F.R. 404.1527(d)(2)(i), (d)(3)-(d)(5). "[E]ven if the treating source's opinion is not such that [the Commissioner] can give it controlling weight, [the Commissioner] will still give the opinion more weight than [she] would have given it if it came from a nontreating source." 56 Fed. Reg. at 36,936; accord *id.* at 36,936-36,937. The Commissioner's regulation further informs claimants that "[w]e will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion." 20 C.F.R. 404.1527(d)(2); 61 Fed. Reg. 34,490, 34,492 (1996) (Soc. Sec. Ruling 96-2p).

The Commissioner's regulations are binding upon courts reviewing the agency's final decision even where the regulations "differ from [a circuit's own prior] version of the treating physician rule in material respects." *Schisler* v. *Sullivan*, 3 F.3d 563, 566, 567, 568 (2d Cir. 1993) (noting that Commissioner's regulations supplanted circuit law by "accord[ing] less deference to unsupported treating physician's opinions," by considering "the length of the relationship between the treating source and the claimant," and by "permit[ting] the opinions of nonexamining sources to override treating sources' opinions, provided they are supported by evidence in the record").

2. The Ninth Circuit in *Regula* imported the Social Security Act's treating physician rule into the ERISA context based on what the court regarded as "common sense" and on an interest in "consistency in [judicial] review of disability determinations where benefits are protected by federal law." 266 F.3d at 1139. The court of appeals erred in equating the two situations. The Social Security Act is a nationwide statutory benefits program paid for by federal funds and subject to uniform administration by the Commissioner of Social Security. Moreover, while there is substantial reason to doubt that the courts of appeals in the 1980s had authority to impose on the Commissioner general standards concerning what weight must be given to treating physician opinions, that issue is now beside the point because the Commissioner in 1991 elected to adopt such a rule in regulations and those regulations now control the adjudication of claims under the program.

The Commissioner has often exercised her "exceptionally broad" authority under 42 U.S.C. 405(a), see *Heckler* v. *Campbell*, 461 U.S. 458, 466 (1983), to establish rules for the receipt and assessment of proof for benefit eligibility under the Act in order to achieve efficiency and uniformity to the processing of over 2.5 million claims for benefits, of which over 200,000 are considered by ALJs. *Cleveland* v. *Policy Mgmt. Sys. Corp.*, 526 U.S. 795, 803 (1999); *Schweiker* v. *Chilicky*, 487 U.S. 412, 424 (1988); *Bowen* v. *Yuckert*, 482 U.S. 137, 153 (1987); *Heckler* v. *Campbell*, 461 U.S. at 460-462. In similar fashion, the Commissioner reasonably determined, in the face of the many but varying court of appeals decisions on the subject, to adopt a treating physician rule that could be applied in a uniform way throughout the Nation. The adoption of regulations by the responsible Executive agency to bring nationwide uniformity to a massive statutory benefits program does not support judicial imposition of a treating physician rule on a broad range of

private and voluntary benefit plans where the responsible Executive agency has not done so and instead has sought to preserve maximum flexibility for the design of such plans and their processing of claims.

Indeed, the treating physician rule has not consistently been applied outside the Social Security context even under other *statutory* disability programs. In addition to the Social Security context, the rule, or some variation of it, has been adopted by some courts in two federal statutory settings. A few courts, in reviewing disability determinations by the Department of Labor's Benefits Review Board under the Longshore and Harbor Workers' Compensation Act (LHWCA), 33 U.S.C. 901 *et seq.*, have embraced a treating physician rule similar to the one developed under the Social Security Act. *Amos* v. *Director, OWCP*, 153 F.3d 1051, 1054 (9th Cir. 1998), cert. denied, 528 U.S. 809 (1999); *Pietrunti* v. *Director, OWCP*, 119 F.3d 1035, 1042 (2d Cir. 1997).

Additionally, courts reviewing decisions by the Benefits Review Board under the Black Lung Benefits Act (BLBA), 30 U.S.C. 901 *et seq.*, have adopted a less deferential version of a treating physician rule that permits, but does not require, hearing officers to defer to the opinions of treating physicians. *National Mining Ass'n* v. *Department of Labor*, 292 F.3d 849, 861 (D.C. Cir. 2002) (noting "consensus among [the] courts * * * that an agency adjudicator may give weight to the treating physician's opinion when doing so makes sense in light of the evidence and the record, but may not mechanistically credit the treating physician solely because of his relationship with the claimant."). In 2000, the Department of Labor adopted a regulation on the subject under the BLBA that "attempted to codify principles embodied in case law." 64 Fed. Reg. 54,966, 54,969 (1999).

That regulation permits (but does not require) the hearing officer to give "controlling weight" to a treating physician's opinion "in light of its reasoning and documentation, [and]

other relevant evidence and the record as a whole." 20 C.F.R. 718.104(d)(5); *National Mining Ass'n*, 292 F.3d at 861, 870-871 (upholding regulation and noting that it "codifies judicial precedent and does not work a substantive change in the law"). In issuing the regulation, the Department stated that it "is not an outcome-determinative evidentiary rule," because it permits the adjudicator to "consider[] the credibility of the physician's opinion in light of its documentation and reasoning and the relative merits of the other relevant medical evidence of record." 65 Fed. Reg. 79,920, 79,923 (2000). The Department also distinguished its regulation from the one governing Social Security claims, explaining that the Social Security rule "demonstrates an affirmative preference for reports from treating physicians." 65 Fed. Reg. at 79,934.

In two other federal statutory disability programs, courts have rejected a treating physician rule outright and the responsible federal agency has declined to adopt one. In *White* v. *Principi*, 243 F.3d 1378, 1381 (Fed. Cir. 2001), the court of appeals held that the Board of Veterans' Appeals need not accord special weight to treating physician opinions in determining entitlement to veterans' benefits for service-connected disabilities because nothing in the federal statute that permits the Board to consider evidence, 38 U.S.C. 7104(a), "suggest[s] that the VA should give more weight to a piece of evidence based solely on its source." Similarly, in *Dray* v. *Railroad Retirement Board*, 10 F.3d 1306 (7th Cir. 1993), the court rejected a treating physician rule for disability determinations under the Railroad Retirement Act of 1974, 45 U.S.C. 231 *et seq.*, reasoning that "[i]n the case of dueling doctors, it remains the province of the [finder of fact] to decide whom to believe—a treating doctor whose experience and knowledge about the case may (or may not) be relevant to understanding the claimant's condition, or a

consulting specialist who may bring expertise and knowledge about similar cases." *Dray*, 10 F.3d at 1311.

A majority of state courts likewise have rejected a treating physician rule under state worker's compensation statutes. *Conradt* v. *Mt. Carmel Sch.*, 539 N.W.2d 713, 717 (Wis. Ct. App. 1995) (noting majority rule and observing that "[a] handful of states allow trial courts to give greater deference to the testimony of an attending physician, yet without creating a presumption that this is so") (emphasis removed); see generally 8 Arthur Larson & Lex K. Larson, *Larson's Workers' Compensation Law* § 130.05D[4][b] (2002) (discussing state court decisions). Some courts rejecting a treating physician rule have reasoned that it would unduly interfere with discretion accorded the finder of fact to weigh conflicting medical opinions.[8] Other courts have questioned the wisdom of categorically deferring to the opinions of treating physicians.[9] For similar reasons, New York courts

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[8] *Doyle* v. *Public Employees' Retirement Sys.*, 808 So. 2d 902, 907 (Miss. 2002) ("The law contains no such duty of deference [to the treating physician], and * * * this Court cannot reweigh the facts."); *Dillon* v. *Whirlpool Corp.*, 19 P.3d 951, 953-954 (Or. Ct. App. 2001) ("[D]ivided medical opinion leaves the Board in the position of evaluating the evidence."); *Conradt*, 539 N.W.2d at 716 ("[I]t is for [the state commission] to decide if one expert's testimony is more persuasive than another's."); *Ashe* v. *Workmen's Comp. Appeal Bd.*, 648 A.2d 1306, 1308 (Pa. Commw. Ct. 1994) ("[T]he weighing of testimony is solely within the province of the referee, and his decision to accept testimony of one competent witness over another will not be disturbed on appeal."); *Gibson* v. *City of Lincoln*, 376 N.W.2d 785, 791 (Neb. 1985) (" 'trier of fact' remains the sole judge of a witness' credibility and the testimony's weight").

[9] *McClanahan* v. *Raley's Inc.*, 34 P.3d 573, 577 (Nev. 2001) ("We do not agree that because a physician has a duty to cure a patient that the physician will necessarily be more familiar with an issue."); *Gibson*, 376 N.W.2d at 791 ("Generally, an expert witness' firsthand knowledge is a factor which may affect such witness' credibility and weight given to the testimony from that expert, but presence or absence of firsthand knowledge does not, by itself, necessarily establish preference or priority in evidentiary value.").

have rejected the treating physician rule for disability determinations under the State's employee retirement system. *E.g.*, *Irish* v. *McCall*, 747 N.Y.S. 2d 610, 611 (App. Div. 2002) ("[W]e have adhered to the view that the Comptroller is vested with the authority to resolve conflicts in medical opinion and credit the testimony of one medical expert over another.").

These authorities demonstrate the absence of a generally accepted treating physician rule applicable to statutory disability determinations. The Ninth Circuit thus erred in concluding that a treating physician rule under ERISA is necessary to ensure uniformity of judicial decisions reviewing disability determinations—even assuming, arguendo, that it was the proper role of that court to bring uniformity to disparate statutory programs.

C. The Case Should Be Remanded For Further Proceedings In Which Special Weight Need Not Be Given To The Opinions Of Respondent's Treating Physicians

The Ninth Circuit held that Black & Decker's dual status as funding source and plan administrator created a conflict of interest (Pet. App. 8-9) and that the plan administrator's failure to apply a treating physician rule in those circumstances constituted a breach of fiduciary duty (*id.* at 8-14). The court of appeals further held that such a breach triggered a de novo standard of judicial review, and under that standard, no disputed issue of material fact existed as to whether respondent was disabled. *Id.* at 14-15. The United States agrees that the employer's dual role in funding the plan and deciding claims under it created a conflict of interest that triggered a requirement of more searching judicial review under *Firestone*, 489 U.S. at 115, and petitioner did not seek review of the court of appeals' ruling to that effect.

See also Pet. App. 31 (district court opinion) ("Defendant * * * concedes that there is an apparent or technical conflict of interest due to Black & Decker's dual role as insurer and administrator.").[10] Nor has petitioner challenged the court of appeals' further conclusion that, once a claimant provides material evidence that such a conflict of interest in turn actually affected the administrator's decision to deny benefits and thereby resulted in a breach of fiduciary duty, a de novo standard of review is appropriate unless the plan produces evidence that no such breach occurred. *Id.* at 9-15. Nonetheless, the Ninth Circuit's judgment should be set aside, for two reasons.

First, the court held that a de novo standard of review was required based in part on its erroneous view that ERISA plan administrators are required to follow the treating physician rule as set forth in *Regula*. Pet. App. 8-15. In particular, the court of appeals relied on the administrator's failure to follow that rule as evidence that petitioner's conflict of interest actually influenced the administrator's decision and constituted a breach of fiduciary duty. *Id.* at 9, 12, 14.

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[10] Under *Firestone*, "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187, cmt. d (1959)). Courts have differed on whether a conflict of interest is present where the fiduciary both decides a claim for benefits and is responsible for paying the claim out of its own assets. Compare Pet. App. 8-9; *Yochum* v. *Barnett Banks, Inc. Severance Pay Plan*, 234 F.3d 541, 544 (11th Cir. 2000); *Pinto* v. *Reliance Standard Life Ins. Co.*, 214 F.3d 377, 391-392 (3d Cir. 2000); *Peruzzi* v. *Summa Med. Plan*, 137 F.3d 431, 433 (6th Cir. 1998); *Doe* v. *Group Hospitalization & Med. Servs.*, 3 F.3d 80, 86-87 (4th Cir. 1993), with *Bill Gray Enters., Inc. Employee Health & Welfare Plan* v. *Gourley*, 248 F.3d 206, 216-217 (3d Cir. 2001); *Kimber* v. *Thiokol Corp.*, 196 F.3d 1092, 1098 (10th Cir. 1999); *Davolt* v. *Executive Comm. of O'Reilly Auto.*, 206 F.3d 806, 809 (8th Cir. 2000).

Second, even if a de novo standard of review was appropriate in this case, the court of appeals erred in concluding that "[t]he administrative record reveals no genuine dispute as to whether [respondent] is disabled within the meaning of the plan." Pet. App. 15. As the court of appeals acknowledged, Dr. Mitri, a neurologist whom petitioner retained for an independent medical examination and evaluation, cf. 29 C.F.R. 2560.503-1(h)(3)(iii), opined that respondent "should be able to perform sedentary work, with no material limitations in his ability to sit, while taking pain reduction medication." Pet. App. 5. The judgment below should accordingly be reversed so that the Ninth Circuit, without regard to a treating physician rule, may reconsider the appropriate standard of review and determine whether, under that standard, to affirm the district court's decision or instead to reverse and remand for further proceedings.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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FEBRUARY 2003